New Jersey Department of Health and Senior Services
Office of Home and Community Services
Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders
PO Box 807
Trenton, NJ 08625-0807

FINANCIAL PROFILE

Name of Client	Name of Agency
Street Address	Social Security Number
City, State, Zip Code	County
Name of Primary Caregiver	Relationship
Street Address	Telephone Number ( )
City, State, Zip Code	

Yearly Income of Client or Couple (if Married)			Assets of Client or Couple (if Married)		
Type	**Value**	**Specify Type of Verification on File**	**Type**	**Value**	**Specify Type of Verification on File**
Wages			Bank Account Balances		
Social Security (before Medicare is deducted)			Value of Stocks		
SSI			Value of Bonds		
VA			Value of CD's		
Pensions			Value of Annuities		
Interest, Dividends, Trusts			Cash Surrender Value of Life Insurance		
Other			Other		
Total Income					
Adjusted Income*			Total Value of Assets		

**Submit Form WFS-11 Extraordinary Financial Obligations if reporting adjusted income.*

Marital Status	Living Arrangements
☐ Single ☐ Divorced	☐ Alone ☐ With Family
☐ Married ☐ Widowed	☐ With Spouse Only ☐ Other

CERTIFICATION: I certify that the above is true and accurate to the best of my knowledge.

Signature of Primary Caregiver	Date
Name of Agency Representative	Title
Signature	Date

Distribution: Original-NJDHSS Copy-Agency Copy-Family